CARE PLANS

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

A facility was cited for not involving the resident and family "enough" in the care planning process. This specific facility extends an invitation to the resident to attend the care planning process, but since the family usually can not attend, the family meets with the staff after the care plan has been developed to review and make changes to the care plan. The surveyor stated that the family had to be accommodated and present during the care planning process even if it meant holding care planning meetings at 7:00 pm at night.

There is no basis for such a citation. Regarding the care planning process, facility staff should refer to regulations 42 CFR §483.20(d)(3), tag F280. The emphasis on the care planning process is with resident involvement. Meetings should be scheduled to accommodate the resident's schedule/routine. Families should be involved if the resident is agreeable to this involvement or if the resident is incapable or otherwise incapacitated. Care plan meetings do not have to be scheduled to meet a family's working schedule, but this would facilitate their involvement in this process. Alternatives, such as a separate meeting to review, revise, and approve the plan would meet the regulation.

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In order to have the care plan easily accessible to the nursing assistants, can the care plan be placed at the bedside on a clipboard or in a folder? For confidentiality purposes the plan would be placed in a colored plastic slip before being put on the clipboard or in the folder. Also, can resident care information, like splints and positioning equipment be posted at the head of a resident's bed?

Yes, if the resident or resident's surrogate, representative, or responsible party gives consent.

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FILE TOPIC: Care Plans

Does every medical problem have to be addressed in the resident care plan even if it is not a current problem?

No. Both Licensure and Certification have rules which require that the facility identify resident's current needs/problems, goals, and interventions (PCP) with evaluation of care at least quarterly and revision/updating as needed. A medical diagnosis does not automatically result in a resident "need". Further information should be gathered to clarify if there is a resident problem associated with the diagnosis.

An example of "no resident problem" might be a diagnosis of hypertension with a 5-10 year history of stable/normal blood pressure on medication therapy, and good dietary compliance. All the resident's needs are being met by the medication and diet orders and no nursing or other discipline intervention is needed to compensate for a deficit in the resident's ability to meet his own needs.

The Resident Assessment Instrument (RAI) through triggering mechanisms and resident assessment protocol review indicate which items should be considered through the care planning process.

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FILE TOPIC: Care Plans

Are nursing diagnoses required on resident care plans? (Examples: ineffective airway clearance, impaired adjustment to facility, activity intolerance due to immobility)

No. There are no regulatory requirements for the use of nursing diagnoses on care plans. Resident care plans must identify "needs, goals, plans and effectiveness of intervention in a timely manner."

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FILE TOPIC: Care Plans

Must resident care plans reflect specific medications and treatments as an approach?

The care planning process dictates the appropriateness of inclusion of medications or treatments. The resident's needs should dictate whether medications and treatments are care planned. It is up to the care plan team, resident and/or family to determine what areas should be addressed.

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FILE TOPIC: Care Plans

Where should the social work care plan be found - with the interdisciplinary care plan or with individual social history and social work notes?

There is no regulatory requirement for a separate social work plan. Psychosocial needs are to be identified and incorporated into the resident's assessment and interdisciplinary care planning process along with all identified needs.

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FILE TOPIC: Care Plans

Is there a requirement for a care planning conference?

There is no regulatory requirement for a care planning "conference". Interdisciplinary care planning may be carried out in many ways. The facility is free to choose the method which is best in any given situation.

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FILE TOPIC: Care Plans

May facilities combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs)?

Facilities may combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs). In fact, in many cases RAP review should link together multiple indicators under one problem/need. The rationale for combining and linking problems should be included in the documented RAP review. Clinical disagreement does not equal non-compliance when the care planning rationales are clearly documented and are within acceptable standards of practice.

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FILE TOPIC: Care Plans

Is there a requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan?

No. There is no requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan. Examples of these types of acute episodes are short term alterations in the residents physical and functional condition such as the flu; minor infections including readily resolved and nonrecurrent UTIs and URIs; minor injuries resulting from routine day to day living and not precipitated by a change in condition; non-acute and nonrecurrent GI disturbances; etc.

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FILE TOPIC: Care Plans

Is there a requirement for separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review)?

No. Separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review) are not required. Additional assessment is driven by the individual needs of each resident and the resident assessment protocols, and should follow the same interdisciplinary model. Progress notes are required for goals addressed on the care plan. Should problems be recognized by staff that are not triggered by the MDS, additional assessments and notes by disciplines may be indicated.

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FILE TOPIC: Care Plans

Is there a requirement that each discipline list a problem/need on the care plan?

No. There is no requirement that each discipline list a problem/need on the care plan. There is no requirement that each problem/need have an approach listed for each discipline unless that discipline's intervention is indicated and appropriate.

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FILE TOPIC: Care Plans

Are individualized approaches, rather than generalized approaches, required for effective care planning?

Yes. Individualized approaches, rather than generalized approaches, are required for effective care planning. Examples of generalized approaches that should not need to be listed on care plans include but are not limited to: "bathe", "dress", "feed", "groom", "nourishments". These terms result in "canned" plans that tend to address all problems generically for all residents with that particular need. Individualized care plans do not plan routine care but plan for the individualized approach necessary to accomplish that routine care. Individualized plans would address issues regarding a resident's bathing needs that are unique for him; what differing types of nourishments should be offered; etc.

Because strengths and weaknesses are considered during the RAP process, it is not necessary to list them on the care plan.

Task segmentation and goal segmentation (short term goals) should be used to individualize the care plan.

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FILE TOPIC: Care Plans

Is there a requirement that dictates how facilities involve residents and physicians in care planning?

No. There is no requirement that dictates how facilities involve residents in their care planning. Input into the care planning process should be accomplished based on the individuals condition, capabilities, and preferences. This input may be accomplished in private discussions at the bedside or, if the resident chooses, in a conference setting. Similarly, there is no requirement that dictates the manner in which physicians participate in the care planning process.

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Are discharge plans or post discharge plans required for in-house transfers such as level of care changes?

No

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FILE TOPIC: Care Plans

Is it necessary to continue to review at each resident care conference vital parameters if all vital parameters are stable?

No. The regulation states that the comprehensive care plan must be, "periodically reviewed and revised...after each assessment." The assessment directs the review of the care plan. If vital parameters had been a problem on the care plan they would need to be reviewed to determine if they were still a problem. If vital parameters had been included in a goal, they would need review to determine if the goal had been reached or if the goal needed to be revised or eliminated.

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FILE TOPIC: Care Plan

Do facilities have to create a care plan document for every resident within 24 hrs of admission that includes problem/need measurable objectives, implementation of approaches, etc. in addition to the care plan developed as a culmination of the RAI process?

No, a "care plan document" is not required. The facility should assess and address specific resident areas that need to be managed via MD orders, treatment records, Medication Administration Records, assessments, etc. The records should contain evidence that the care is being provided as needed until the comprehensive assessment is completed.

The references below specifically state that the initial care plan process begins on day 1 and includes problems and immediate interventions.

The **Guidance to Surveyors for tag F281** (May 1999) states "Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan?"

The **Guidance to Surveyors for tag F309** (June 1995) states, "If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided".

The Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0 (January 2008) speaks to the formulation of the care plan. It says, "For an Admission assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident."